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Physician Injectable Drug List (PIDL) Review Request Form

The request to consider coverage of additional injectables or changes to existing injectable drugs will be completed in the order received. The goal is to complete the review and respond to requests within 30 days of receipt of the completed form. For detailed information regarding the PIDL policy refer to Part II Policy and Procedure Manual for the PIDL. All Medicaid policy manuals for the Georgia Department of Community Health (DCH) are accessible online at www.ghp.georgia.gov; click on the "Provider Information" tab; then the "Medicaid Provider Manuals" link.

Name of office Contact: Practice/Company Name: Address:	Request Date:		
Number: Practice/Company Name: Address: City, State Zip Phone: FAX: Email: REQUEST Request consideration to: Open new injectable drug Chg or add new indication(s) to already approved drug Chemical Name: Brand Name: HCPCS/CPT Code(s): Dose/Unit: NDC(S): AWP/Unit: Does the manufacturer offer rebates on the drug at this time? If not FDA approved, date application submitted? Is there a specific Medicaid eligible patient pending this determination? If yes, please indicate patient's name and Medicaid ID# Briefly summarize your request in the space provided below and attach any supporting documentation you wish to be considered: Submit completed request electronically to: medicalpolicy@dch.qa.gov for receipt by: Medical Policy Unit/PIDL Review Georgia Department of Community Health DCH USE ONLY PBM Consulted (V/N) Approved/Denied Maximum Allowable Maximum City, Briffective Date	REQUESTOR CONTACT INFORMATION		
Address:	Provider Name & Number:	Name of office Contact:	
Request consideration to:	Practice/Company Name:		
Phone: FAX: Email: REQUEST	Address:	City, State Zip	
Request consideration to:	Dhana	FAV.	
Request consideration to:	DECLIEST		
Chemical Name: HCPCS/CPT Code(s): Dose/Unit: NDC(S): AWP/Unit: Does the manufacturer offer rebates on the drug at this time? ICD-9 Code(s) FDA Approval Indications(s): If not FDA approved, date application submitted? Is there a specific Medicaid eligible patient pending this determination? If yes, please indicate patient's name and Medicaid ID# Briefly summarize your request in the space provided below and attach any supporting documentation you wish to be considered: Submit completed request electronically to: medicalpolicy@dch.ga.gov for receipt by: Medical Policy Unit/PIDL Review Georgia Department of Community Health DCH USE ONLY PBM Consulted (Y/N) Approved/Denied Maximum Allowable Maximum Units PA Required (Y/N) Effective Date	Peguest consideration to		
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NDC(S): AWP/Unit: Does the manufacturer offer rebates on the drug at this time? Yes No	Chemical Name:	Brand Name:	
Does the manufacturer offer rebates on the drug at this time?	HCPCS/CPT Code(s):	Dose/Unit:	
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PBM Consulted (Y/N) Approved/Denied Maximum Allowable Maximum Units PA Required (Y/N) Effective Date	Medical Policy Unit/PIDL Review		
Approved/Denied Maximum Allowable Maximum Units PA Required (Y/N) Effective Date			
Maximum Allowable Maximum Units PA Required (Y/N) Effective Date		Comments:	
Maximum Units PA Required (Y/N) Effective Date			
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Effective Date			
requestor notined (1/1v)			
Date Review Completed	<u> </u>		
Reviewer Initials	· <u> </u>		